DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/07/13

PRINTED: 10/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. BUILDING _____ B. WING _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE GENESIS HEALTHCARE	136 DAVIS LANE LAFOLLETTE, TN 37766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy and interview, the facility failed to ensure family notification, related to a	F 157	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cumberland Village Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies." F 157 1. Resident # 210 was provided a roommate notification form on 10/23/13 by the Social Service Director. 2. An audit of all residents that received a new roommate since 10/1/13 was conducted by the Social Service Director or designee on 10/25/13. Other residents with new roommates had been notified. 3. The Director of Nursing or designee conducted re-education with licensed staff and social work staff for completion of room change notifications for residents on 10/30/13	11/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/14/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 roommate change, for one resident (#210), of thirty-five residents reviewed. The findings included: Resident #210 was admitted to the facility on August 14, 2013, with diagnoses including Dementia, Bipolar Disorder, Anxiety State, Thrombocytopenia, and Altered Mental Status. Medical record review of the quarterly Minimum Data Set (MDS), dated August 21, 2013, revealed the resident scored a four on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired, and required limited assistance with activities of daily living. Medical record review of an Interdisciplinary Progress Note, dated August 22, 2013, written by Social Service worker #1, revealed "...spouse visits frequently and is very supportive..." Observation on October 22, 2013, at 10:20 a.m. in the resident's room, revealed the resident in the room lying on the bed watching television. Interview with the resident's family member, on October 21, 2013, at 3:24 p.m., in the resident's room, revealed the family member was not notified of a roommate change. Interview with Licensed Practical Nurse (LPN) #1, on October 23, 2013, at 10:20 a.m., in the secured unit nurse's station, revealed "...resident's ... (spouse) is very active in the resident's care...wants to be called for any changes in the resident's condition...we notify...of any changes...social services would notify the family of roommate charges..."	F 157	4. The Social Service Director or designee will complete an audit of room change notifications for residents weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit of room change notifications on residents during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 157	Continued From page 2 Interview with Social Service Worker,#1, on October 23, 2103, at 10:25 a.m., in the Social Service office, revealed "...there was a roommate change on September 26, 2013...there is a form we complete if a roommate change occurs ...do not see the roommate change form on the chart..." Review of the Information and Rights for Patients and Residents, revealed "...the center will also promptly notify you, and if known, your legal representative, or designated family member when there is a change in room or roommate assignment..." Interview with the Social Service Director, on October 23, 2013, at 10:35 a.m., in the Social Service office, confirmed "...would document the notification of the family on the "change of roommate form"...do not see the form in the resident's record..."	F 157	1. Resident #82's care plan was updated to address their urinary incontinence on 10/23/13 by the Clinical Case Manager. 2. An audit of other incontinent residents was conducted by the Director of Nursing or designee by 11/15/13. Those residents with incontinence were reviewed and no other issues were identified. 3. The Director of Nursing or designee conducted re-education with care plan staff on care planning incontinence on 11/12/13.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	4. The Director of Nursing or designee will complete an audit of residents with incontinence weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit for incontinent residents during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	11/25/13

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F 279	Continued From page 3 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a care plan to address urinary incontinence for one resident (#82) of thirty-five residents reviewed. The findings included: Resident #82 was admitted to the facility on June 28, 2013, with diagnoses including Diabetes, Hypertension, Atrial Fibrillation, Depressive Disorder, Anorexia, Senile Dementia with Delirium and Hypothyroidism. Medical record review of the "Bowel and Bladder Continence Evaluation" form dated July 10, 2013, through July 12, 2013, revealed the resident had ten episodes of urinary incontinence out of fifty-one episodes of hourly checking documented. Further review of the "Bowel and Bladder Continence Evaluation" form revealed the form was not completed to determine the type of incontinence and what type of training program the resident should be placed on. Medical record review of the care plan did not reveal any care planning for incontinence or a bladder training program.	F 279		

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F 279	Continued From page 4 Interview with the Director of Nursing (DON) on October 22, 2013, at 3:50 p.m., in the conference room, confirmed there were no interventions care planned for incontinence or for a bladder training program.	F 279	1. Resident #169's family was notified and a care plan meeting took place on 10/24/13.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to conduct a quarterly care plan review and involve the family in the care planning conference of one resident (#169) of thirty-five residents reviewed.	F 280	2. An audit of other residents with quarterly care plans due in September and October was conducted by The Social Service Director or designee on 10/29/13. Those residents that were due quarterly care plan meetings were reviewed and no other issues were identified. 3. The Director of Nursing or designee conducted re-education with Social Service staff on conducting quarterly care plan reviews on 10/29/13. 4. The Social Service Director or designee will complete an audit of residents due a quarterly care plan weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit for residents due a quarterly care plan during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent	11/29/13

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F 280	Continued From page 5 The findings include: Resident #169 was admitted to the facility on April 15, 2013, with diagnoses including Cerebral Vascular Accident, Dementia, Coronary Artery Disease, Hypertension, Diabetes Mellitus, Depression, and Anxiety Disorder. Medical record review revealed an admission care plan but no documentation of a quarterly care plan meeting involving the family or the resident. Phone interview with the resident's family member on October 22, 2013, at 4:13 p.m., revealed...had not been invited to attend a care planning conference. Review of the "Social Service Assessment and Documentation Policy" dated effective March 1, 2013, revealed "...Quarterly Documentation...the social service director/designee completes a review of residents at least quarterly..." Interview with the Social Worker on October 23, 2013, at 10:10 a.m., in the Admissions Office revealed "...usually send a letter, speak in person, or call the family and then document in the (interdisciplinary) notes whether the family attends or not..." Continued interview with the Social Worker in the conference room on October 23, 2013, at 10:22 a.m., confirmed "...I missed it, the quarterly should have been done in September sometime and I missed it..."	F 280	plans of correction will be implemented as necessary. **1.** The discharge summary on resident's #150, #157, #196 & #228 was completed by 11/15/13 and mailed to their home address. **2.** An audit of residents that had an anticipated discharge from the facility since 10/1/13 was conducted by the Social Service Director or designee by 11/15/13. Those residents had a discharge summary completed by 11/15/13 and mailed to their home address. **3.** The Director of Nursing or designee conducted re-education with Social Service staff on ensuring residents that had an anticipated discharge from the facility have a discharge summary completed on 10/31/13. **4.** The Social Service Director or designee will complete an audit of residents that had an anticipated discharge from the facility weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review	
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283		

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F 283	Continued From page 6 When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide a completed discharge summary for four residents (#150, #157, #196, #228), of forty records reviewed. The findings included: Resident # 150 was admitted to the facility on May 10 ,2013 ,From an acute care hospital , with diagnoses of Hypertension, Gastroesophogeal Reflux, Multi Resistant Organism, Diabetes Mellitus, , and Arthritis.The resident was discharged home on August 5, 2013. Medical record review of the resident's admission record revealed no discharge summary was completed. Resident # 157 was admitted to the facility on August 19,2013, from home, with diagnoses of Hypertension, Gastroesophogeal Reflux, Urinary Tract Infection, Diabetes Mellitus, Thyroid Disorder, Arthritis, Osteoporosis, Alzheimer's disease, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease.The ressident was discharged home on September 30, 2013.	F 283		

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F 283	Continued From page 7 Medical record review of the resident's admission record revealed no discharge summary was completed. Resident # 196 was admitted to the facility on July 19,2013, from an acute care facility, with diagnoses of Gastroesophogeal Reflux, Pneumonia, Diabetes Mellitus, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease.The ressident was discharged home with home July 30 ,2013. Medical record review of the resident's admission record revealed no discharge summary was completed. Resident # 228 was admitted to the facility from an acute care hospital, on May 5,2013, with admitting diagnoses of Cancer without Metastasis, Coronary Artery Disease, Benign Prostatic Hypertrophy, Diabetes Mellitus, Hyperlipidemia, Thyroid Disorder, Cerebrovascular Accident, Anxiety, Depression, and chronic Obstructive Pulmonary Disease.The ressident was discharged home on May 25, 2013. Medical record review of the resident's admission record revealed no discharge summary was completed. Interview with the Director of Nursing, on October 22,2013, at 10:40 a.m., in the conference room, confirmed no discharge summaries had been completed for residents # 150, #157, #196, and #228.	F 283		

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F 315	Continued From page 8	F 315	and analyze the results of the audit for	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review and interview, the facility failed to provide treatment and services for incontinence, for one resident (#82), of thirty-five residents reviewed. The findings included: Resident #82 was admitted to the facility on June 28, 2013, with diagnoses including Diabetes, Hypertension, Atrial Fibrillation, Depressive Disorder, Anorexia, Senile Dementia with Delirium and Hypothyroidism. Medical record review of the "Nursing Assessment" form dated June 28, 2013, revealed "...Bladder habit: Continent Yes..." Medical record review of the "Bowel and Bladder Continence Evaluation" form dated July 10, 2013 through July 12, 2013, revealed the resident had ten episodes of urinary incontinence out of fifty-one episodes of hourly checking	F 315	residents that had an anticipated discharge from the facility during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary. **F 315** **1.** Resident #82 was re-assessed by a licensed nurse and the care plan was updated to address their urinary incontinence on 10/23/13 by the Clinical Case Manager. **2.** An audit of other incontinent residents was conducted by the Director of Nursing or designee by 11/15/13. Those residents with incontinence were reviewed and no other issues were identified. **3.** The Director of Nursing or designee conducted re-education with care plan staff on care planning incontinence on 11/12/13. **4.** The Director of Nursing or designee will complete an audit of residents with incontinence weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or	11/25/13

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F 315	Continued From page 9 documented. Further review of the "Bowel and Bladder Continence Evaluation" form revealed the form was not completed to determine the type of incontinence and what type of bladder training program the resident should be placed on. Medical record review of the care plan did not reveal any care planning for incontinence or a bladder training program. Review of the facility policy "Continence Management Program" revealed "...The urinary incontinence program uses the 'APIE' approach to care giving-Assess, Plan, Implement, Evaluate...Identify each resident who is incontinent of urine, assess and plan appropriate treatment and services to achieve or maintain as much normal urinary function as possible...provide service to restore or improve normal bladder function to the extent possible..." Interview with the Director of Nursing (DON) on October 22, 2013, at 3:50 p.m., in the conference room, confirmed the nursing assessment had been marked incorrectly regarding continence status, the bowel and bladder continence evaluation was incomplete and there were no interventions on the care plan for incontinence. Continued interview confirmed the facility failed to provide resident #82 treatment and services to restore bladder function.	F 315	designee will review and analyze the results of the audit for incontinent residents during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	11/25/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F441 F 441	1. The clean linen closet on the 300 front hallway was cleaned by housekeeping supervisor on 10/23/13. Residents in room 307, 308, 309, and 310 on were assessed for signs and symptoms of infection by the licensed nurse on 10/21/13 with no adverse findings. Resident #10 and Resident #54 had their oxygen tubing replaced and dated by the central supply clerk on 10/21/13. The ice chest on the secured unit was emptied and sanitized by the infection control nurse on 10/21/13. The ice pitchers were exchanged for clean pitchers by the infection control nurse on 10/21/13. 2. An audit was conducted on the infection control log by the infection control nurse on 11/6/13 with no evidence of cross-contamination identified. Residents receiving oxygen therapy had their nasal cannulas	

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F 441	Continued From page 10 of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and, interview, the facility failed to maintain one of one clean linen storage closet observed, in a sanitary manner, failed to provide sanitary	F 441	changed and dated on 11/4/13 and as needed. Water Pitchers on the secured unit hallway were changed on 10/21/13. 3. Staff was educated by the Director of Nursing or designee on proper hand-washing techniques, proper technique for ice delivery, infection control practices related to meal delivery, proper maintenance of clean storage areas, and proper handling/dating of oxygen tubing. 4. Director of Nursing or designee will observe ice pass delivery and meal delivery 3 times weekly for 4 weeks and 1 time weekly for two months. Director of Nursing or designee will observe oxygen tubing for proper storage/dating and infection control practice 3 times weekly for 4 weeks and 1 time weekly for two months. The Administrator or designee will analyze results of the audits for infection control during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	11/25/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445276	A. BUILDING _____ B. WING _____	10/23/2013

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F 441	Continued From page 11 distribution of food trays and ice, and failed to provide sanitary administration of oxygen by nasal cannula. The findings included: Observation on October 21, 2013, at 9:40 a.m., in the clean linen closet on the 300 front hallway revealed: 1. A disposable glove turned inside out with a large dark substance visible on the inside of the glove. 2. A single loose garbage bag laying on the floor next to the shelving unit. 3. An opened 60 milliliter (ml) syringe laying under the lowest shelf on the floor . 4. A white wash cloth laying on the floor under the lowest shelf. Interview with Licensed Practical Nurse (LPN) #3 on October 21, 2013, at 9:45 a.m., in the hallway outside the linen closet, confirmed the clean linen closet was not clean and sanitary. Observation and interview of the 300 hall food tray delivery on October 14, 2013, at 12:50 p.m., revealed two Certified Nursing Aides (CNA'S) #1 and #2, served trays to multiple rooms, (room 307, 308, 309, and 310), without washing hands. Review of facility policy "Infection Control Policies and Procedures,IC203 Hand Hygiene" revised September 1, 2010, revealed, "Process; wash hands with soap and water in the following situations: 1.6 :Before and after handling food." Interview with the CNA's in the 300 hall at the time of serving trays, confirmed they did not wash hands between residents.	F 441		

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F 441	Continued From page 12 Observation of resident #10 on October 21, 2013, at 10:20 a.m.,and resident #54 on October 21 ,2013, at 10:21 a.m., revealed oxygen nasal cannulas (tubing that delivers oxygen to the nose) not dated and lying on the floor. Interview with Licensed Practical Nurse (LPN) # 1, in the residents' rooms, confirmed the cannulas were not dated and were lying on the floor. Observation on October 21, 2013, at 12:45 p.m., on the Secured Unit Hallway, revealed Certified Nursing Aide (CNA) #3 passing ice on the Secured Unit. Continued observation revealed CNA #3 entered the resident's room (room 126), exited the resident's room with the dirty ice pitcher, filled the resident's dirty ice pitcher with the ice, holding the pitcher over the top of the clean opened ice chest and returned the dirty ice pitcher back into the resident's room. Observation on October 21, 2013, at 3:00 p.m., on the Secured Unit Hallway, revealed CNA #4 passing ice on the secured unit. Continued observation revealed the CNA entered two resident's rooms (rooms 123 and room 124) and brought the dirty ice pitchers outside of the room into the hallway. Further observation revealed the CNA filled the dirty ice pitchers with ice, holding the pitcher over the top of the clean opened ice chest and returned the dirty ice pitchers back into the resident's rooms. Interview with CNA #3, on October 21, 2013, at 12:47p.m., in the secured unit hallway, confirmed the CNA filled the dirty ice pitcher with ice holding the the ice pitcher over the top of the opened ice chest.	F 441		

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F 441	Continued From page 13 Interview with CNA #4, on October 21, 2013, at 3:05 p.m., in the Secured Unit hallway, confirmed CNA #4 filled the dirty ice pitcher with ice holding the ice pitcher over the top of the opened ice chest. Interview with Licensed Practical Nurse (LPN) #1, on October 21, 2013, at 3:30 p.m., in the Secured Unit Nurses station, confirmed the CNA #3 and CNA #4 failed to ensure safe infection control standards by holding and filling the dirty ice pitcher over the opened ice chest.	F 514 F 441	1. Physician Orders for Resident #239, #64, #230, and #190 and the telephone order for Resident #64 was signed by their physicians by 11/15/13. 2. Discharge Summaries and Telephone orders written since 10/1/13 were audited by the Health Information Manager for physician signatures. All medical records with identified issues were corrected and signed by their physician by 11/15/13.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the physician signed the discharge summary's for four residents (#239, #64, #230, and #190) and failed to sign a telephone order for one (#64) resident of forty residents reviewed.	F 514	3. Director of Nursing Services or designee educated the Health Information Manager regarding accurate completion of the medical record on 11/1/13. 4. Health Information Manager will audit discharge summaries and telephone orders weekly for four weeks and monthly for two months. The Administrator or designee will review and analyze the results of the audit for complete medical records during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent	

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F 514	Continued From page 14 The findings included: Medical record review revealed Resident #239 was admitted to the facility on June 26, 2013, with diagnoses which included Congestive Heart Failure and Cardiac Atherosclerosis. Continued review revealed the resident was discharged home on July 18, 2013. Review of the Discharge Summary dated July 18, 2013, revealed the summary was not signed by the physician as of October 23, 2013. Medical record review revealed resident #64 was admitted to the facility in June 30, 2013 and discharged on July 12, 2013, with diagnoses including Coronary Artery Disease, Hypertension, Heart Failure and Gastrointestinal Reflux. Medical record review of resident #64's Discharge Summary, dated July 12, 2013, revealed a telephone order written by Registered Nurse (RN) #1 for the discharge summary, dated July 12, 2013, and the physician had not signed the discharge summary or the telephone order as of October 23, 2013. Medical record review revealed resident #230 was admitted to the facility on May 3, 2013 and discharged on June 5, 2013, with diagnoses including Anemia, Hypertension, Gastrointestinal Reflux and Arthritis. Medical record review of the Discharge Summary dated June 5, 2013, revealed the physician had not signed the discharge summary as of October 23, 2013.	F 514	plans of correction will be implemented as necessary.	11/25/13

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F 514	Continued From page 15 Resident #190 was admitted to the facility on August 20, 2013, with diagnoses including Pathologic Fracture of Upper Arm, Traumatic Fracture of Lower Arm, Diabetes, Asthma and Anxiety. Medical record review revealed the discharge summary completed on September 16, 2013, was not signed by a physician as of October 23, 2013. Interview with the Director of Nursing (DON) on October 22, 2013, at 3:30 PM, in the conference room, confirmed the physician failed to sign the discharge summaries for four residents (#239, #64, #230, and #190) and failed to sign a telephone order for resident #64.	F 514		